STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155274	A. BUILDING 00 B. WING	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	815 W WASHINGTON ST ROCKPORT, IN47635

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F0000	This visit was for the Investigation of Complaint IN00092349. Complaint IN00092349 Substantiated, Federal/State deficiencies related to the allegations are cited at F282, F314, and F514. Unrelated deficiency cited. Survey dates: June 28 and 29, 2011 Facility number: 000174 Provider number: 155274 AIM number: 100274810 Survey team: Anne Marie Crays RN Census bed type: SNF: 4 SNF/NF: 49 Total: 53 Census payor type: Medicare: 11 Medicaid: 24 Other: 18 Total: 53 Sample: 3 These deficiencies also reflect state	F0000	Please accept this credible allegation of compliance to the findings of the complaint survey conducted June 28 and 29, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	findings cited in accordance with 410 IAC 16.2. Quality review completed 7/1/11 Cathy Emswiller RN			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure an air mattress ordered by the physician was turned on, for an unknown time frame, and failed to implement pressure relief for a resident with a pressure ulcer	F0282	It is the practice of this facility to provide services according to the plan of care. Resident B had her bed turned on immediately. The bed was assessed for function by maintenance and monitored by nursing for proper functioning for 24 hours and maintained in good	07/29/2011

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	on her foot, for 2 of 3 residents reviewed with pressure ulcers, in a sample of 3. Resident B, Resident A Findings include: 1. On 6/28/11 at 10:00 A.M., Resident B was observed lying in bed. The resident complained of "aching all over." The resident was observed to be lying on an air mattress, operated by a mechanical pump. The air mattress was observed to be turned off. CNA # 2 indicated at that time that Resident B would be getting up for lunch "around 11:30 A.M. or so." On 6/28/11 at 10:20 A.M., during interview, the Director of Nursing [DON] indicated he was going to do a skin assessment on Resident B. The resident's buttocks appeared red, with 2 superficial scratch-like open areas, approximately the size of a dime. No dressing was observed on the buttocks. The buttocks had a white ointment on them. The resident complained that the bed was uncomfortable. The DON was interviewed regarding if the air mattress was turned on. The DON checked the bed, and indicated it was not on. On 6/28/11 at 10:25 A.M., the Unit Manager provided a CNA assignment sheet. The sheet indicated Resident B had		working order. Resident B's care plan was reviewed and reflects current intervention. Resident A had her wheelchair footrest padded to reduce pressure. Resident A's care plan was reviewed and reflects current intervention. All residents with an air mattress have the potential to be affected. An audit of all air mattresses was conducted to ensure proper function. All are in working order and all care plans reflect the current intervention. All Residents with pressure areas have been observed to have appropriate pressure reducing devices in place and the care plans reflect the current intervention. The wound nurse and Director of Nursing or designee will be notified the day of discovery of any new pressure ulcers. The nursing staff, including C.N.A.'s will be updated on all pressure ulcers and proper devices to be in place as per the care plan. All Nursing staff will be re-educated on: A) The proper use and function of air mattresses, including the need to re-check them for inflation after a power surge or outage. All air mattresses will be placed on Treatment Sheets for nurses to document that they checked them for proper function each shift. The C.N.A.'s will be informed on all air mattress usage; however, the nurses will be responsible for checking them. B) The Policy and Procedure on the "The Care	

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	a "Pressure Relief Device, low air loss mat [mattress]." On 6/28/11 at 10:45 A.M., during interview, the DON indicated he performed an audit on all of the air mattresses in the facility, and they were all turned on. The DON indicated he spoke to all of the staff, and "no one can remember turning it off." The clinical record of Resident B was reviewed on 6/28/11 at 11:05 A.M. Diagnoses included, but were not limited to, Senile Dementia. A Care Plan, initially dated 4/2/10 and with a target date of 7/22/11, indicated, "Potential for skin breakdown related to risk factors as listed on skin risk assessment et [and] circulatory system, long term steroid therapy use." The Interventions did not included an air mattress. On 6/28/11 at 11:30 A.M., the DON indicated "there was a power surge earlier this morning, before I got here, and it probably didn't kick back on." The DON indicated he did not know how long the bed had been left off. On 6/29/11 at 8:45 A.M., the DON provided the manufacturer's instructions		Plan Development and Review". This will cover all the points as they relate to following and updating air mattresses and pressure reducing interventions. Air mattresses will be monitored each shift by the nurse on duty as stated. Nurse Manager will also monitor daily using the Air Mattress Check Tool for 30 days, weekly for 4 weeks, and monthly thereafter. See attachment A. Pressure reducing/relieving devices will be monitored for proper placement as indicated on care plan. This will be done each shift by the charge nurse and also done 5 days a week by the Unit Manager or designee then weekly ongoing using the Pressure Ulcer Interventions Q. A. tool. See attachment B. The QA tool for "Pressure Ulcer Risk Reduction and Treatment Review" will also be completed weekly X 4 then monthly thereafter. See Attachment C The results of the audits will have immediate corrections if needed and the audit results will be reviewed at the monthly Quality Assurance Committee Meeting. Any recommendations made will then be followed. The D.O.N. or designee will be responsible for all of the above.	

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	for the air mattress. The instructions indicated, "The digital controlled pump unit, which provides adjustable pressure and cycle time, is compact and effective in pressure control and management...." On 6/29/11 at 1:30 P.M., during interview with the DON and RN # 1, they indicated they put the air mattress on the resident's bed on 6/7/11, due to a report of the resident having open areas on her buttocks. 2. On 6/28/11 at 9:25 A.M., during the initial tour, the Director of Nursing [DON] indicated Resident A had a pressure ulcer on her right outer foot. A skin assessment was requested at that time. The resident was observed to be sitting up in a Broda chair, with both of her feet on a footrest. Cushioning was not observed under the resident's feet. The resident's right outer foot was observed to have a contracture, allowing the outer portion of her foot to rest against the footrest. The DON removed the resident's socks, and a small black scabbed type area, surrounded by slight redness, was observed on the resident's right outer foot. A dressing was not observed on the area. The DON placed a pillow under the resident's right foot, and indicated he thought a previous chair had caused the area, and the chair had been changed to a			

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	Broda chair. The DON indicated the resident was now receiving hospice services. The clinical record of Resident A was reviewed on 6/28/11 at 10:05 A.M. Diagnoses included, but were not limited to, Parkinson's Disease and Dementia. A nursing assessment, dated 6/17/11 at 1:21 P.M., indicated, "...New wound description: (suspected pressure, vascular, or diabetic ulcer)...1. Location(s)...Outer right foot. Measures 0.5 x 0.7 Dark tissue, skin intact, edges even, erythema [redness] noted from edges to 0.7 x 1.0, No drainage, pain, odor...." A Progress Note, dated 6/17/11 at 6:18 P.M., indicated, "...Duoderm thin to area on right outer foot x 5 days then remove and re eval. Daughter aware." A Progress Note, dated 6/21/11 at 11:35 A.M., indicated, "...Area to right foot right side shows improvement [sic], blood blister type area remains. 0.5 x 0.7 dark area remains, appears to be a flat blood filled blister. No redness around area. Pressure prevention in place, no shoes on right foot, bil [bilateral] feet elevated in bed. Order to continue with duoderm x 5 more days then reassess...."			

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	A Physician's order, dated 6/25/11, indicated, "1. D/C [discontinue] Duoderm thin to [right] outer foot. 2. Monitor blood blister to [right] outer foot Q [every] shift." A Care Plan, initially dated 12/22/05 and updated 6/21/11, indicated, "At risk for skin breakdown/pressure d/t [due to] episodes of incontinence with bowel and bladder, non ambulatory, et [and] requires extensive staff assist with bed mobility. Dry skin noted to upper et lower extremities." Interventions included: "Enc [encourage] and assist w [with] turning and repositioning every two hours and as needed. Weekly skin assessment. Pressure reducing device to bed and chair...." On 6/28/11 at 12:40 P.M., the Administrator provided an additional care plan, which indicated, " Area to right foot right outer side blood filled blister area. Date Initiated: 6/21/2011, Revision on: 6/28/2011." The Interventions indicated, "Resolved: Duoderm thin to area x 5 days then reassess. Pressure relief devices in use. Monitor for placement q shift. Date initiated: 6/21/2011, Revision on: 6/28/2011. Monitor q shift for changes, Update MD, hospice of worsening, No shoe to right foot. Date initiated: 6/25/2011." The Administrator indicated there was not a care plan regarding the			

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	right foot pressure area until 6/21/11. The Administrator indicated any nurse can develop a care plan. The Administrator did not indicate what specific pressure relief devices were to be in place for the resident. This Federal tag relates to Complaint IN00092349. 3.1-35(g)(2)			

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F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to implement interventions to treat and prevent a pressure ulcer on a foot, for 1 of 3 residents reviewed with pressure ulcers, in a sample of 3. Resident A Findings include: 1. On 6/28/11 at 9:25 A.M., during the initial tour, during interview, the Director of Nursing [DON] indicated Resident A had a pressure ulcer on her right outer foot. A skin assessment was requested at that time. The resident was observed to be	F0314	It is the practice of this facility to implement interventions to treat and prevent pressure ulcers. Resident A had her wheelchair footrest padded to reduce pressure. Resident A's care plan was reviewed and reflects current intervention. Resident A is monitored every shift and prn for placement of pressure reducing devices. All residents with pressure ulcers have the potential to be affected by this practice. All Residents with pressure areas have been observed to have appropriate pressure reducing devices in place and the care plans reflect the current	07/29/2011

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	sitting up in a Broda chair, with both of her feet on a footrest. Cushioning was not observed under the resident's feet. The resident's right outer foot was observed to have a contracture, allowing the outer portion of her foot to rest against the footrest. The DON removed the resident's socks, and a small black scabbed type area, surrounded by slight redness, was observed on the resident's right outer foot. A dressing was not observed on the area. The DON placed a pillow under the resident's right foot, and indicated he thought a previous chair had caused the area, and the chair had been changed to a Broda chair. The DON indicated the resident was now receiving hospice services. The clinical record of Resident A was reviewed on 6/28/11 at 10:05 A.M. Diagnoses included, but were not limited to, Parkinson's Disease and Dementia. A Braden scale, to determine risk of development of pressure ulcers, dated 4/20/11, indicated the resident scored a 9, which indicated, "Very High Risk." A Minimum Data Set [MDS] assessment, dated 4/26/11, indicated Resident A required extensive assistance with two+ staff for bed mobility and transfer, and had no pressure ulcers.		intervention. The wound nurse and Director of Nursing or designee will be notified the day of discovery of any new pressure ulcers. The nursing staff, including C.N.A.'s will be updated on all pressure ulcers and proper devices to be in place as per the care plan. All Nursing staff will be re-educated on: A.)The Policy and Procedure on the "The Care Plan Development and Review". This will cover all the points as they relate to following and updating air mattresses and pressure reducing interventions. B.) The Policy and Procedure on "Skin Management Program" which addresses pressure reducing devices, care planning implementation, assessment and documentation of pressure ulcers. The D.O.N./Unit Manager or designee will audit the care plans and placement of pressure ulcer reducing devices for those with pressure ulcers for proper placement as indicated on care plan. This will be done each shift by the charge nurse and also done 5 days a week by the Unit Manager or designee then weekly ongoing using the Pressure Ulcer Interventions Q. A. tool . See attachment B. The QA tool for "Pressure Ulcer Risk Reduction and Treatment Review" will also be completed weekly X 4 then monthly thereafter. See Attachment C The results of the audits will have immediate corrections if needed and the	

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	A nursing assessment, dated 6/10/11 at 9:05 A.M., indicated the resident had no skin alterations or pressure wounds. A nursing assessment, dated 6/17/11 at 1:21 P.M., indicated, "...New wound description: (suspected pressure, vascular, or diabetic ulcer)...1. Location(s)...Outer right foot. Measures 0.5 x 0.7 Dark tissue, skin intact, edges even, erythema [redness] noted from edges to 0.7 x 1.0, No drainage, pain, odor...." A Progress Note, dated 6/17/11 at 6:18 P.M., indicated, "...Duoderm thin to area on right outer foot x 5 days then remove and re eval. Daughter aware." The resident was evaluated by hospice on 6/17/11, and obtained a Broda chair. A Progress Note, dated 6/21/11 at 11:35 A.M., indicated, "...Area to right foot right side shows improvement [sic], blood blister type area remains. 0.5 x 0.7 dark area remains, appears to be a flat blood filled blister. No redness around area. Pressure prevention in place, no shoes on right foot, bil [bilateral] feet elevated in bed. Order to continue with duoderm x 5 more days then reassess...." A Physician's order, dated 6/25/11,		audit results will be reviewed at the monthly Quality Assurance Committee Meeting. Any recommendations made will then be followed. The D.O.N. or designee will be responsible for all of the above.	

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	indicated, "1. D/C [discontinue] Duoderm thin to [right] outer foot. 2. Monitor blood blister to [right] outer foot Q [every] shift." A Care Plan, initially dated 12/22/05 and updated 6/21/11, indicated, "At risk for skin breakdown/pressure d/t [due to] episodes of incontinence with bowel and bladder, non ambulatory, et [and] requires extensive staff assist with bed mobility. Dry skin noted to upper et lower extremities." Interventions included: "Enc [encourage] and assist w [with] turning and repositioning every two hours and as needed. Weekly skin assessment. Pressure reducing device to bed and chair...." On 6/28/11 at 12:40 P.M., the Administrator provided an additional care plan, which indicated, " Area to right foot right outer side blood filled blister area. Date Initiated: 6/21/2011, Revision on: 6/28/2011." The Interventions indicated, "Resolved: Duoderm thin to area x 5 days then reassess. Pressure relief devices in use. Monitor for placement q shift. Date initiated: 6/21/2011, Revision on: 6/28/2011. Monitor q shift for changes, Update MD, hospice of worsening, No shoe to right foot. Date initiated: 6/25/2011." The Administrator indicated there was not a care plan regarding the right foot pressure area until 6/21/11. The			

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	Administrator indicated any nurse can develop a care plan. The Administrator did not indicate what specific pressure relief devices were to be in place for the resident. On 6/28/11 at 10:25 A.M., the Unit Manager provided a CNA assignment sheets. The sheet indicated Resident A was to be turned every 2 hours, required a "Pressure Relief Device" of a chair cushion, and was a "Skin/Fall Risk." Comments included: "...Knee hight [sic] ted hose on in am and off at hs [bedtime]...." Documentation regarding a pressure ulcer on the right foot was lacking. 2. On 6/28/11 at 2:10 P.M., the Administrator provided the current facility policy on "Skin Management Program," dated 2010. The policy included: "It is our policy to assess for and reduce risk factors that may contribute to the development of pressure ulcers and other skin alterations...Care Plan Implementation:...Interventions will be implemented according to the individual residents [sic] risk factors that will best reduce the risk of development of pressure...and/or promote the most effective healing of existing areas. The plan of care will be updated with all changes to treatments or to other			

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	interventions as they occur. Prevention and treatment interventions will include but are not limited to the following major categories: Nutritional support; medication therapy; risk reducing products...Repositioning for the Prevention of Pressure Ulcers: Repositioning should be done to reduce the duration and magnitude of pressure over vulnerable areas of the body...." This Federal tag relates to Complaint IN00092349. 3.1-40(a)(2)			

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F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a clip alarm ordered by the physician for fall prevention was attached to a wheelchair, for 1 of 1 residents reviewed for falls, in a sample of 3. Resident B Findings include: 1. On 6/28/11 at 10:25 A.M., the Unit Manager provided a CNA assignment sheet. The assignment sheet indicated Resident B utilized a wheelchair, and was a "Skin/Fall Risk." Documentation of the need for an alarm was lacking. On 6/28/11 at 11:05 A.M., the clinical record of Resident B was reviewed. Diagnoses included, but were not limited to, Senile Dementia and Fractured Right Wrist. Nursing Progress Notes included the following notations: 6/3/11 at 7:36 A.M.: "...6am Res [resident] was found laying in the floor on	F0323	It is the practice of this facility to ensure alarms for fall preventions are in place. Resident B had her alarm put in place. The care plan was updated. Nurses and C.N.A.' s were informed of use of alarm. The placement and function of the alarms is checked each shift by the charge nurse and documented on the treatment record. All residents with alarms have the potential to be affected. Residents using alarms were reviewed to ensure the physician order and care plan were correct. The placement and function of the alarms is checked each shift by the charge nurse and documented on the treatment record. Nursing staff will be re-educated on: Fall Management Policy & Procedure Alarm use & Maintenance Policy & Procedure Nursing will monitor for proper function and placement of alarms each shift. The Director of Nursing or designee will complete the Alarm Audit Tool daily for 30 days, weekly for 4 weeks, and monthly thereafter. See Attachment D.The results of the Audits will have immediate corrections if needed and the	07/29/2011

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	155274	A. BUILDING 00 B. WING	06/29/2011

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	right side. Assessment done. Res does complain of right wrist hurting...." 6/3/11 at 8:45 P.M.: "Xray of r [right] wrist fx [fracture] lower end of radius in satisfactory aligment [sic]...." A Physician's order, dated 6/3/11, indicated, "Clip alarm while up in chair. Check function and placement every shift." Nursing Progress Notes continued: 6/27/11 at 3:49 P.M.: "Type: Physician order...D/C [discontinue] clip alarm when in recliner. Keep clip alarm when in w/c...." A Care Plan, initially dated 3/4/10 and with a target goal date of 7/22/11, indicated, "Fall Risk characterized by risk factors as listed on the fall risk assessment. History of falls...Weakness." The Interventions did not include the use of an alarm. On 6/28/11 at 11:40 A.M., Resident B was observed sitting in a wheelchair in the dining room. A cast was observed on her right arm. An alarm was not observed on the chair. CNA # 1 was interviewed at that time, and indicated Resident B did not utilize an alarm.		audit results will be reviewed at the monthly Quality Assurance Committee Meeting. Any recommendations made will then be followed. The D.O.N. or designee will be responsible for all of the above.	

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	On 6/28/11 at 12:05 P.M., during interview with the Administrator, she indicated any nurse could update or create a care plan. On 6/28/11 at 2:05 P.M., the Administrator provided a revised care plan. The Administrator indicated the care plan mistakenly did not include the clip alarm as a fall prevention intervention. The revised care plan for "Fall Risk" now included: "6/27/11 Clip alarm while up in w/c. Nursing to check function et [and] placement q [every] shift." On 6/29/11 at 1:05 P.M., RN # 1 indicated the CNA assignment sheets are updated "at least weekly." 2. On 6/29/11 at 8:45 A.M., the Director of Nursing [DON] provided the current facility policy on "Fall Management Procedure, dated 2003-2011." The policy included: "...Procedure:... C. The interdisciplinary health care plan team will determine which interventions are most appropriate for reducing the risk of falls...D. Update the plan of care each time there is a change in intervention and communicate it to staff...." 3.1-45(a)(2)			

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, interview, and record review, the facility failed to ensure documentation was complete in regard to a resident returning from the hospital on 2 different occasions, and failing to document observation of a skin rash when first discovered, as well as on-going observations, for 1 of 3 residents reviewed for documentation, in a sample of 3. Resident B Findings include: On 6/28/11 at 10:15 A.M., Resident B was observed lying in bed. A skin assessment was requested at that time. The DON assisted the resident to turn. The resident's buttocks were observed to be very reddened and blanchable, with scratch-like areas observed. The DON indicated the resident had scratched herself, because she was allergic to the briefs.	F0514	It is the practice of this facility to ensure all records are complete and accurate. Resident B had had her record updated with late entry on for 6/7/11 indicating the orders she received from the doctor while out to the emergency room visit. A complete review of the resident's documentation for the trips in and out of the hospital was completed to clarify. The emergency room visits of 6/8/11 and 6/17/11 were really doctor appointments that the office arranged to have the physician. meet her in the emergency room for her convenience and were not true emergency room visits. All residents have the potential to be affected. All transfers to and from the hospital will be monitored and audited for documentation reflecting this. Nursing will be educated on: 1) New Admission & Return to Facility Policy & Procedure 2) Charting Policy & Procedure 3) Transfer to Hospital or Another Facility Policy & Procedure. The above policy & Procedures also include proper	07/29/2011

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	The clinical record of Resident B was reviewed on 6/28/11 at 11:05 A.M. The record included the following notations: 6/7/11 at 9:48 A.M.: "When bathing res [resident] blood clots were noted coming from rectum. Orders received from [physician] to send res to [hospital]...." Documentation of when the resident returned from the hospital was lacking in the clinical record. A Progress note indicated, "Late Entry 6/7/2011 12:45 [P.M.]...Cleanse buttocks with remedy foam cleanser, et apply Calzamine cream after each incontinent episode et [and] PRN [as needed]. Res to only wear pull ups." A nursing assessment, dated 6/8/11 at 12:15 P.M., indicated: "...Rash and/or Excoriation description: 3 x 1 1/2 rash on L [left[buttock, 1.5 x 1.5 rash on R [right] buttock, Areas red, no odor, no drainage, denies pain. Res recently started wearing briefs, et [and] areas look to be an allergic reaction. Res has continued to scratch buttocks. Res to go back to wearing only pull-ups. Nursing to clean buttocks with cleanser, et apply Calzamine cream...." A Progress note indicated, "Late Entry 6/9/2011 at 10:52 [A.M.]...Area to		documentation of all head to toe skin assessments and care planning of pertinent issues. Medical Records will do admission audits and ongoing audits as a double check system for needed documentation. DON or designee will monitor using Resident Transfer QA tool daily for one month, weekly for 4 weeks and monthly thereafter. See Attachment E. The results of the audits will have immediate corrections if needed and the audit results will be reviewed at the monthly Quality Assurance Committee Meeting. Any recommendations made will then be followed. The D.O.N. or designee will be responsible for all of the above.	

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	buttocks shows improvement. This nurse went in to assess et tx [treat]. Res incontinent of bladder...res states 'I didn't know I had to go...' Nurse informed staff to monitor frequently for incontinence." The resident was transferred to the hospital on 6/13/11. A transfer form indicated, "Skin Condition Upon Transfer:...Right buttock, Left buttock, rash, due to allergic reaction to briefs...." Documentation on when the resident returned to the facility was lacking in the clinical record. A progress note, dated 6/13/11 at 10:49 A.M., indicated, "...Give Cipro...Start initial dose when she returns to the facility...." A nursing assessment, dated 6/14/11 at 3:13 P.M., indicated the resident had no skin alterations. On 6/29/11 at 11:30 A.M., the DON indicated the resident probably needed some sort of anti-fungal cream. On 6/29/11 at 12:10 P.M., RN # 1 provided the current June 2011 treatment record for Resident B. The record indicated: "6/7/11, 6A-6P, Cleanse buttocks w Remedy Foam cleaner et apply Calzamine Remedy cream after each			

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	incontinent episode et PRN..." The record was marked as completed every day since 6/7/11 except for 6/16, 6/17, and 6/19. On 6/29/11 at 12:10 P.M., during interview with RN # 1 and the DON, they indicated they could not find documentation of when the resident returned to the facility, or further documentation of the skin issues on Resident A. RN # 1 indicated the facility does not do nursing reassessments on residents if they have not been gone for 24 hours, but that the resident's skin was assessed on 6/7/11. RN # 1 indicated she did not know why it was not documented. This Federal tag relates to Complaint IN00092349. 3.1-50(a)(1)			

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